STATE BOARD OF WORKERS' COMPENSATION

Guidelines On Completion Of Basic Claims Processing Forms

~ Introduction ~

This handbook provides simple step-by-step instructions on the completion of basic claims processing forms relative to benefit payments as mandated by the State Board of Workers' Compensation. It is primarily intended as a handy reference for insurers, self-insurers and third party administrators.

Please contact the Training Section of the State Board of Workers' Compensation at (404) 656-3697 for information on additional resources on the Georgia Workers' Compensation System.

(Rev. 7/03)

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THE CLAIMS PROCESS/ WHO, WHAT, WHEN, AND WHERE

(Rev. 7/03)

FORM WC-1 EMPLOYER'S FIRST REPORT OF INJURY OR OCCUPATIONAL DISEASE

WHAT: The initial report of an injury sustained by the employee that has or is expected to result in medical services and/or lost time from employment.

WHO TO WHOM: The employer completes Section A of the form and the wage statement on the back and submits it to its insurer.

WHEN: **IMMEDIATELY UPON KNOWLEDGE OF AN INJURY**

COMPLETING SECTION A OF THE WC-1:

- Enter the name, address, city and zip code of the employer.

- Enter the employer's phone number.

- Enter the insurer/self-insurer name.

- Enter the employer's FEIN number.

- Enter the nature of the employer's business.

- Enter OSHA file number, if applicable.

- Enter the specific insurer file number which identifies the claim. (This number is entered by the insurer.)

  Please note:

  Form WC-1 should show the complete name and address of the insured employer including all names the employer may use for the business. The name and claims address of the individual insurer must be provided. If claims are serviced by a third party administrator (TPA) the insurer's name and the

name and address of the TPA must be shown in the box provided.

Example:

Employer
John Doe d/b/a Doe's Auto Repair
123 Main Street
Hometown, GA 30303-3030

Insurer/Self-Insurer
Jones Insurance Co.

TPA/Claims Office
Smith Claims Service
P.O. Box 9999
Atlanta, GA 30303-9999

The complete name and address of the self-insured employer must be shown in the employer block, including the name as it appears on the self-insurer permit. The name as it appears on the permit and the complete address of the claims office must be provided in the insurer block. If claims are serviced by a TPA, the self-insurer's name and the name and address of the TPA must be shown in the box provided.

Example:

Employer
Local Services Co./Regional Conglomerate,Inc.
345 Market Street
Hometown, GA 30303-4040

Insurer/Self-Insurer Name
Regional Conglomerate, Inc.

TPA/Claims Office
Smith Claims Service
P.O. Box 9999
Atlanta, GA 30303-9999

- Enter TPA FEIN number, if applicable.

- Enter TPA/Claims Office phone number.

- Enter the Employer's location address if different from the address previously shown in the employer address block.

- Enter the address or location where the accident or exposure occurred.

- Enter the job classification code.

- Enter the name and address of the injured employee (last name first.)

- Enter injured employee's date of birth.

- Enter the county where the accident or exposure occurred.

- Enter the date of the injury as reported by the injured employee.

- Enter employee's social security number CORRECTLY PLEASE!

- Enter the employee's home phone number or a number where the employee can be reached.

- Enter the number of the employee's dependents including the spouse.

- Check whether the injured employee is male or female.

- Enter the time that the accident or exposure occurred.

- Enter the time the employee's workday began.

- Enter the date the employee reported the injury to a representative of the employer.

- Enter the date the employee was hired.

- Check whether the employee worked the next day following the accident or exposure.

- Enter the first date the employee failed to work a full day because of the injury or exposure.

- Check whether the employee received full pay for the date of injury.

- Enter the number of employee's regularly scheduled hours PER DAY and PER WEEK.

- Enter the number of days the employee normally worked per week.

- List the normally scheduled off days (Sat., Sun., etc.)

- Enter the employee's wage rate at the time of injury or disease. (Check hour, day, week, or month.)

- If the employee is paid hourly, on commission or piecework basis, enter average weekly amount.

- Enter the average weekly amount of board, lodging, or other compensation furnished to the employee.

- Check whether the accident or exposure occurred on the employer's premises.

- Enter type of illness or injury.

- Enter part of body affected by the injury.

- Describe how the injury or illness/abnormal health condition occurred and what the employee was doing prior to the accident.

- Enter the date the employee returned to work following the most recent disability period.

- Enter the wage per week at which the employee returned to work.

- If fatal, enter date of death.

- Enter the name and address of the treating physician.

- Check the degree of initial treatment.

- Check whether or not the employer is utilizing a Board Certified Workers' Compensation Managed Care Organization (WC/MCO.)

- If the employee was treated at a hospital/treating facility, enter the name and address of the facility.

- Print or type the name of the person preparing the Form WC-1.

- Enter the position or job title and telephone number of the person preparing the Form WC-1.

- Enter the date the Form WC-1 was completed.

FORM WC-1 SECTION B

Section B of Form WC-1 is used to commence weekly benefits and to suspend weekly benefits when the employee has actually returned to work at the time the Form WC-1 is filed with the Board. In all other cases, the insurer should file Form WC-2 to commence or suspend benefits. If the injury results in death, a Form WC-2a must be completed.

WHO TO WHOM: The insurer/self-insurer completes Section B and submits the original to the State Board of Workers' Compensation and a copy to the employee.

WHEN: **WITHIN 21 DAYS OF THE EMPLOYER'S KNOWLEDGE OF DISABILITY.**

COMPLETING SECTION B OF THE FORM WC-1:

- Enter the employee's average weekly wage.

- Enter the employee's weekly benefit amount.

- Enter the date of the employee's disability.

- Enter the date the first payment of benefits is made to the injured employee.

- Enter the amount of compensation paid to the employee, or the amount of salary paid.

- Enter the amount of any penalties paid.

- Check whether the claim was previously medical only.

- Enter the date from which benefits are payable to the injured employee.

- Check the type of income benefit being paid:

* Permanent partial disability payments are computed from the Summary of Provisions Table included in this manual on page 9 and also on the back of the Form WC-2.

- Enter the return to work date when the employee has actually returned to work at the time of filing.

- Type or print the name of the insurer or self-insurer representative completing the form.

- Sign the form and enter the date and telephone number.

FORM WC-1 SECTION C

When the right to income benefits or other compensation is denied or disputed, in whole or part, at the time the Form WC-1 is filed, Section C of the Form WC-1 is completed.

WHO TO WHOM: The insurer/self-insurer completes Section C and submits the Form WC-1 to the State Board of Workers' Compensation with a copy to the employee and any other persons with a financial interest including, but not limited to, the employer, attorneys, and providers of medical services.

WHEN: **ON OR BEFORE THE TWENTY-FIRST DAY AFTER THE EMPLOYER'S KNOWLEDGE OF THE ALLEGED INJURY.**

COMPLETING SECTION C OF THE FORM WC-1:

Additional space is provided on the reverse side of the Form WC-1 for the information required.

- State the specific grounds upon which the right to compensation is controverted, i.e., medical, indemnity or all issues. The employee or potential beneficiary is entitled to know precisely why and to what extent the claim is being controverted. General statements such as "liability is not being accepted pending investigation" or "the right is reserved to controvert on further grounds" are not acceptable.

- Indicate whether the claim is controverted in whole (all issues) or in part (only medical or income benefits). Examples:

  "The injury did not arise out of or in the course of employment." (whole claim)

  "Medical provider is not an authorized doctor." (only medical)

  "Lost time over the waiting period was not authorized by the treating physician and was not related to the injury." (income benefits only)

- Type or print the name of the insurer or self-insurer representative completing the form.

- Sign the form and enter the date and phone number.

FORM WC-1 WAGE STATEMENT (reverse side)

WHAT: A form for calculating the average weekly wage of the employee or deceased worker at the time of the injury.

WHO TO WHOM: The employer/self-insurer completes Form WC-1, Section A and the wage statement on the back of the form and submits the form to the insurer or TPA.

WHEN: **IMMEDIATELY UPON KNOWLEDGE OF THE INJURY.**

COMPLETING THE FORM:

CALCULATION OF THE AVERAGE WEEKLY WAGE

The employer must use the gross weekly wages of the injured employee for 13 weeks immediately preceding the injury. Weeks prior to this period are disallowed. The injured employee must have worked substantially the whole of the 13 weeks to compute the wage.

If the injured employee has not worked substantially the whole of 13 weeks immediately preceding the injury, the employer/insurer must use the gross weekly wages of a

similar employee in the same employment who has worked substantially the whole of 13 weeks preceding the injury. The name of the similar employee should be entered in the space provided at the top of the form.

If the 13-week wage statement of the injured employee or a similar employee cannot reasonably and fairly be applied, the employer's insurer must use the full time weekly wage of the injured employee.

ADDITIONAL BENEFITS

Computation of wages shall include, in addition to salary, hourly pay, or tips, the reasonable value of food, housing and other benefits furnished by the employer without charge to the employee which constitute a financial benefit to the employee and are capable of monetary calculation.

PART-TIME OR TEMPORARY EMPLOYEE

Unless the contrary appears, it is assumed that a normal workweek is five days, that the normal workday is eight hours, and that the employee's daily wage is one-fifth of the weekly pay. Fractional parts of the day shall be credited proportionately in computing the daily wage. For example, the daily wage of a five and one half-day worker is the weekly wage divided by 5.5.

CONCURRENT OR SIMILAR EMPLOYMENT

If the employee has similar concurrent employment, the wages paid by all similar concurrent employers shall be included in calculating the average weekly wage.

FILING RELATED TO AVERAGE WEEKLY WAGE

The wage statement should be completed with the initial filing of the Form WC-1 when benefits are commenced. Forms WC-1 or WC-2 must show payment of the maximum weekly benefits under O.C.G.A. §34-9-261 or §34-9-262, as applicable, unless Form WC-6, Wage Statement, or another explanation accompanies the Forms WC-1 or WC-2, or is already on file.

FORM WC-2 NOTICE OF PAYMENT OR SUSPENSION OF BENEFITS

WHAT: Form WC-2 is the form to report the commencement, suspension, or change in income benefits, classification, or rating of disability.

WHO TO WHOM: The insurer/self-insurer sends the original to the State Board of Workers' Compensation. A copy of both sides of this form must be given to the employee and his/her attorney when payments are started, adjusted, or stopped.

WHEN:

A. SUSPENSION OF INCOME BENEFITS

1. Unilateral Suspension by Insurer/Self-Insurer

The first use of Form WC-2 is to suspend the weekly benefit payment when a change in disability status occurs after Form WC-1 has been properly filed with the Board. The form is used to notify the employee and the Board of suspension of income benefits. Form WC-2 is the proper form to report any change in income benefits, classification, or rating of disability. Form WC-3, Notice to Controvert, is intended to deny liability in whole or in part after Form WC-1 has been filed with the Board, and serves the same purpose as Section C of Form WC-1.

For suspension of income benefits, the insurer/self-insurer files Form WC-2 with the Board, and where needed, Form WC-3 or other documents as stated below, and furnishes a copy to the employee when:

a. The employee returns to work for the same or another employer at a wage equal to or exceeding the average weekly wage at the time of the disabling injury.

b. The employee is deemed able to return to work without limitation. The insurer/self-insurer must attach supporting medical information from the authorized treating physician to Form WC-2 filed with the Board. The insurer/self-insurer must give the employee ten days advance notice of the suspension of income benefits. Unless there is

compelling evidence to the contrary, the date stamped by the Board as its date of receipt is deemed to be the date the employee received notice.

c. The employee is released to return to work with restrictions and the employee refuses to attempt to perform a suitable job when the requirements of Board Rule 240 are met.

d. The employee dies. The insurer/self-insurer must furnish a copy of the Form WC-2 to the representative of the estate of the deceased employee, if known, and attach a copy of the death certificate, if available. If the insurer/self-insurer contend that the death is unrelated to the injury, a Form WC-3 should accompany the Form WC-2.

e. If within 60 days after the due date of the first payment of income benefits (which is 21 days after the employer's notice or knowledge of a lost time disabling injury or disease), the insurer/self-insurer determine to controvert the payment of income benefits for any reason, a Form WC-3 must be filed with the Form WC-2. The insurer/self-insurer must furnish a copy of the Form WC-3 to all persons having a financial interest including, but not limited to, the employer, attorneys, and providers of medical services. To meet the 60-day deadline the documents must be filed with the Board, as shown by the Board's date stamp, within 60 days after the due date of the first payment of income benefits.

f. If more than 60 days after the due date of the first payment of income benefits (which is 21 days after the employer's notice of a lost time disabling injury or disease), the insurer/self-insurer determine to controvert on the basis of newly discovered evidence, Forms WC-3 and WC-2 must be filed with the Board. O.C.G.A. § 34-9-221 requires that the insurer/self-insurer give the employee 10 days advance notice of the suspension of income benefits. The insurer must furnish a copy of Form WC-3 to all persons having a financial interest including, but not limited to, the employer, attorneys, and providers of medical services.

2. Board Order or Award to Suspend

Unless otherwise specified, a Form WC-2 is not used to suspend benefits which are being suspended pursuant to a Board order or award. When an Administrative Law Judge or the Board issues an order or award suspending benefits, the order or award, is mailed to the address of record of all interested parties and provides authority and notice of the suspension. The basis for a Board ordered suspension of income benefits may include any of the following:

a. The refusal of an employee to accept available work suitable to the employee's capacity to work. This most commonly arises when the authorized treating physician limits the employee to light work, and the employer undertakes to provide suitable light work. Board Rule 240 sets forth the procedures to be followed to effectuate the suspension of income benefits.

b. The refusal of an employee to submit to treatment. O.C.G.A §34-9-200 and 200.1 specify treatment as medical, surgical, hospital care, and vocational rehabilitation, or other treatment provided by law. Board Rules 200(d) and 200.1(h) permit suspension of income benefits only by order of the Board.

c. The refusal of an employee to submit to a medical examination. Board Rule 202(c) permits suspension of income benefits only by order of the Board.

B. CHANGING BENEFITS FROM TEMPORARY TOTAL TO TEMPORARY PARTIAL

When the authorized treating physician has released the employee to return to work with restrictions or limitations as required by O.C.G.A. §34-9-104(a) and the injury is not catastrophic, the insurer/self-insurer must complete Form WC-104. Form WC-104 must be received by the employee or by counsel for the employee within 60 days of the release to return to restricted work by the authorized treating physician. The insurer/self-insurer shall file a copy of the completed Form WC-104 with the Board. If the employee has not returned to work within 52 consecutive weeks or 78 aggregate weeks from the date

the authorized treating physician released the employee to return to restricted work, the insurer/self-insurer is authorized to file a Form WC-2 to change weekly disability benefits from temporary total to temporary partial disability benefits. A copy of the authorized treating physician's report stating the employee's ability to return to work with restrictions or limitations must be attached to the Form WC-2 filed with the Board and Section B.5 on Form WC-2 must specify that the employee's injury has not been described as catastrophic.

For the purposes of calculating temporary partial benefits as contemplated by Code Section 34-9-104(a), benefits shall be paid as follows.

1. When an employee is receiving the maximum benefits for temporary total disability, under Code Section 34-9-261, the employer shall cause to be paid the employee an amount equal to the maximum benefit allowed for temporary partial disability, under Code Section 34-9-262; or

2. When an employee is receiving less than the maximum allowed for temporary total disability, the employer shall continue to pay the employee the same benefits as provided by Code Section 34-9-261 not to exceed the maximum benefit provided for temporary partial disability, under Code Section 34-9-262.

C. RECURRING TOTAL AND TEMPORARY PARTIAL DISABILITY

Where liability is accepted to pay weekly income benefits and a Form WC-1 has been filed, Form WC-2 is used to show the commencement and suspension of benefits. Form WC-2 is used to commence weekly income benefits for recurring disability when:

1. The employee ceases to work for the same or another employer because of the work-related injury, which constitutes a change in condition and not a new accident. An economic loss of wages due to the work-related injury must occur, and this economic loss ordinarily takes place when there is a gradual deterioration of physical condition resulting from the injury, which may or may not be attributable to working conditions subsequent to the injury.

A frequent area of litigation (particularly if one employer and two insurers are involved or if two employers and two insurers are involved) is whether the inability to continue working involves reinstatement of benefits as a change in condition, or whether it is a condition to be treated as a new accident. Consequently, general guidelines only are stated herein, primarily to guide the investigator before seeking legal advice. The questions below will produce facts on which to reach a decision:

a. Is the disability to work due to a gradual deterioration, but not the result of any specific incident at work? If the answer is affirmative, it is likely that a change in condition has occurred.

b. Is the disability to work due to an aggravation of injury by conditions while working for the same employer, but not because of any specific incident? If the answer is affirmative, it is likely that a change in condition has occurred.

c. Is the disability to work due to an aggravation of the injury while working for another employer? Did the new job involve changed work duties, which bear some relationship to the present disability to work? Was there a specific incident while working on the new job which bears some relationship to the disability to work? An affirmative answer to any of these questions is indicative of a new accident instead of a change in condition.

2. The employee ceases to work for the same or another employer because of medical treatment including, but not limited to, therapy, surgery, hospitalization, or medical examination resulting from the work-related injury.

3. The employee ceases to work for the same or another employer and is unable to find any suitable work because of his or her impaired condition resulting from the work-related injury.

4. The employee, although working for the same or another employer, is unable to earn as much or more than his or her average weekly wage at the time of the disabling injury, subject to all of the following conditions:

a. The economic partial loss of earnings results from the work-related injury. This may be due to limitations imposed by the authorized treating physician involving

lifting, movement, number of hours, or due to the lack of suitable work;

b. The economic partial loss of earnings occurs within 350 weeks from the date of injury; and

c. The economic partial loss of earnings is a temporary situation. This is the most frequently overlooked condition to determine whether an employee is entitled to temporary partial disability benefits based on a partial loss of earnings, or permanent partial disability based on a permanent physical impairment. The partial wage loss is defined in the law as a disability to work partial in character and temporary in quality. Thus, if the partial wage loss is one which is a permanent loss, it does not meet the requisite temporary quality. Whether to treat the loss as temporary or permanent depends upon a careful evaluation of various factors, including:

(1) Whether the impairment has reached maximum improvement and whether it temporarily or permanently affects earnings ability.

(2) Whether normal seniority job promotions, vocational rehabilitation training, experience or other variables will cause the employee in the future to increase earnings to the level of the average weekly wage at the time of injury.

D. PERMANENT PARTIAL DISABILITY

1. Entitlement

Form WC-2 is used to commence income benefits for permanent partial disability or to change classification of income benefits to permanent partial disability benefits. The conditions which entitle an employee to permanent partial disability income benefits include all of the following:

a. Not entitled to income benefits for total disability to work.

b. Not entitled to income benefits for temporary partial disability to work.

c. A permanent impairment exists attributable to work-related injury involving the loss of, or the loss of use of a body member or the whole person as listed in the schedule in O.C.G.A. §34-9-263 or entitlement for occupational loss of hearing under O.C.G.A. §34-9-264.

2. Determination of Loss of or Loss of Use of a Body Member.

The determination of the extent of the loss is made by the authorized treating physician and stated in terms of disability to the particular member injured or the whole person. The disability is not a disability to work, but is a physical disability, perhaps better understood if thought of in terms of an impairment.

The percentage of loss or status for certain conditions listed in O.C.G.A. §34-9-263 is controlled by law. These are:

a. Impairment ratings. In all cases arising under this chapter, any percentage of disability or bodily loss ratings shall be based upon Guides to the Evaluation of Permanent Impairment, fifth edition, published by the American Medical Association.

b. Loss of more than one major member. Loss of both arms, hands, legs, or feet, or any two or more of these members, or the permanent total loss of vision in both eyes shall create a rebuttal presumption of compensable permanent total disability.

COMPLETING THE FORM:

1. Form WC-2

Check type of report. Check whether or not the employer is utilizing a Board Certified Workers' Compensation Managed Care Organization (WC/MCO), then provide insurer file number, employee's social security number, date of injury and disability date. Complete the name and address of the employee, and the name,

address, and telephone number of the employer and insurer.

2. Form WC-2 the Body of the Form

a. Part A of Form WC-2

(1) Complete weekly income benefit and average weekly wage. If the weekly income benefit is less than the maximum amount of temporary total disability benefits allowed by law, attach a Form WC-6 to Form WC-2, unless previously filed.

(2) Show the "date benefits are payable from" as the date of disability. If the waiting period is not payable, show the date as the eighth day of lost time after disability.

(3) Check the type of disability and provide the permanent partial disability rating if applicable.

(4) Show the date of the first check as the date the payment is mailed or made to the employee. Timely payments must be mailed from within the State of Georgia by the due date, which is 21 days after the employer's knowledge or notice of lost time disability. Timely payment made from outside the State of Georgia must be mailed no later than three days prior to the due date.

(5) Show the total amount paid and indicate the percentage and amount of any late payment penalties.

(6) When salary is paid in lieu of weekly benefit, give date salary was paid.

b. Part B of Form WC-2

(1) The date of suspension is the date the event occurs which authorizes suspension, except for the 10-day notice to the employee when it is determined that the employee is able to return to normal duty work, but has not returned to work.

(2) The reason for suspension of weekly disability should be indicated, and will be one of the following:

___ B. Benefits will be suspended on ___/___ /_____, because:

___ 1) Employee returned to work on ___/___/_____, without restrictions from the authorized treating physician.

___ 2) Employee returned to work on ___/___/_____, with restrictions from the authorized treating physician, at pre-injury or higher rate of pay.

___ 3) Employee returned to work on ___/___/_____, with restrictions from the authorized treating physician, at reduced pay of $_____ per week, and temporary partial disability benefits are shown in Part A above.

___ 4) Employee was able to return to work on ___/___/_____, without restrictions from the authorized treating physician, the employee is being given ten (10) days notice, and the authorized treating physician's report is attached. (Board Rule 221.)

___ 5) The employee has had a change in condition pursuant to O.C.G.A. §34-9-104(a)(2) because he or she is not working, did not have a catastrophic injury, has been determined by the authorized treating physician to be capable of performing work with limitations or restrictions for the past 52 consecutive or 78 aggregate weeks, and was sent Form WC-104 within sixty (60) days of the release. Temporary partial disability benefits are shown in Part A above.

___ 6) This was not a catastrophic injury and the maximum number of temporary total disability payments has been paid.

___ 7) The entire permanent partial disability benefit has been paid.

___ 8) The maximum number of temporary partial disability payments has been paid.

___ 9) This claim is being controverted within sixty (60) days of the due date of first payment, and a Notice to Controvert, Form WC-3, is being filed with the Board, with a copy sent to the employee.

___10) Other:_____

_____

BY_____

Type or Print and Sign (Date) Phone

(3). Type or print the name of the insurer/self-insurer representative completing the form. Sign the form and enter date and telephone number.

FORM WC-2a NOTICE OF PAYMENT OR SUSPENSION OF DEATH BENEFITS

WHAT: Use to commence, amend, and suspend weekly benefits in death cases.

WHO TO WHOM: The insurer/self-insurer sends the original to the State Board of Workers' Compensation. A copy of both sides of this form must be given to person(s) receiving death benefits and his/her attorney.

WHEN: Submit Form WC-2a when an employee dies, as a result of a work related injury or occupational disease, leaving persons either wholly or partially dependent upon them for support. Also, used to report no dependent payment made to the State Board of Workers' Compensation.

COMPLETING THE FORM:

Check type of report and provide insurer file number, deceased employee's social security number and the date of the injury. Complete the name and addresses of the deceased employee, employer, and insurer.

- Complete Section A to commence death benefits.
- Enter employee's weekly benefit amount.
- Enter the average weekly wage of the deceased employee.
- Enter the date from which death benefits are payable.
- Enter the date the first payment of death benefits is made.
- Enter the amount of the first payment.
- Check whether a penalty payment is included.
- Enter the percentage and amount of any penalties paid.
- Enter the date of death.
- Complete the name, address, telephone number, date of birth and relationship of all total dependents.
- If there are no total dependents, partial dependents may receive benefits.

- If there are no dependents in a compensable death case, the insurer/self-insurer must pay the State Board of Workers' Compensation one-half of the benefits which would have been payable to such dependents or $10,000.00, whichever is less.

- Complete Section B to suspend death benefits. State the reason for the suspension.

- Type or print the name of the insurer/self-insurer representative completing the form.

- Sign the form and enter the date and telephone number.

FORM WC-3 NOTICE TO CONTROVERT

WHAT: Form WC-3 is filed by the insurer/self-insurer when the claim for compensation is denied or disputed in whole or part.

WHO TO WHOM: The insurer/self-insurer files the original form with the State Board of Workers' Compensation. A copy of both sides of the Form WC-3 must be sent to the employee and any other persons with a financial interest in the claim including, but not limited to, the employer, attorneys and providers of medical services.

WHEN: When controverting weekly benefits or other compensation after a Form WC-1 has been filed with the Board. For general guidelines see O.C.G.A. §34-9-221, Board Rule 221, and the back of Form WC-3.

When controverting the claim in whole when weekly benefits are being paid without an award, file within 60 days of the due date of the first payment of compensation along with Form WC-2 suspending benefits. Board Rule 221 (h) (1).

When controverting the claim based on newly discovered evidence if benefits have continued for more than 60 days from the due date of first payment, file along with Form WC-2 giving 10 days advance notice of the suspension. Board Rule 221 (h) (2).

When controverting compensability of medical treatment/test, see O.C.G.A. §34-9-200 and Board Rule 205(b) for general guidelines.

COMPLETING THE FORM:

- Enter the employee's name, address, phone number and CORRECT SOCIAL SECURITY NUMBER.
- Enter the insurer file number.
- Enter the date of injury.
- Enter employer's company name, address and phone number.

- Enter the insurer's name, address, and phone number.

- Check 1 or 2 and state the grounds upon which the right to compensation is controverted.

- List any other person(s) with a financial interest in the claim.

- Type or print the name of the insurer/self-insurer representative completing the form.

- Sign the form and enter the date and telephone number.

FORM WC-4 CASE PROGRESS REPORT

WHAT: Form WC-4 provides a periodic review of a claim. It is the basis for reporting all costs related to an individual claim.

WHO TO WHOM: The insurer/self-insurer sends the original form to the State Board of Workers' Compensation.

WHEN: The following filing guidelines apply:

(a) Within 180 days of the first date of disability;

(b) Within 30 days from last payment for closure;

(c) Upon request of the Board;

(d) Every 12 months from the date of the last filing of a Form WC-4 on all open claims;

(e) To reopen a claim;

(f) With all settlement documents.

(g) Within 90 days of receipt of an open claim by the new third party administrator.

COMPLETING THE FORM:

Check type of report and provide insurer file number, employee's social security number, and date of injury. Complete the names of the employee and employer, and check whether the employer is utilizing a Board Certified Workers' Compensation Managed Care Organization (WC/MCO.)

1. Enter the date of the first payment made to the employee.

2. Enter the type and amount of income benefits paid at the time report is filed. The appropriate subsections follow:

   a. Subsection (a) for temporary total disability income payments under O.C.G.A. §34-9-261.

   b. Subsection (b) for temporary partial disability income payments under O.C.G.A. §34-9-262.

c. Subsection (c) for permanent partial disability income payments under O.C.G.A. §34-9-263. This includes payment made in a lump sum for permanent partial disability.

d. Subsection (d) for death income benefits under O.C.G.A. §34-9-265. Includes payment made in a lump sum. Payment made to the State Board of Workers' Compensation in death cases where there are no dependents must be shown in this section. Burial expenses must be shown in Section 4, Subsection 11.

e. Subsection (e) for lump sum amounts paid for stipulated settlements and advances. Amounts paid for no liability stipulated settlements should also be included in Subsection (e).

Reimbursement of income benefits made by the Subsequent Injury Trust Fund MUST be included in amounts shown in Section 2, and omitted in amounts shown in Section 4(1). The amount of SITF reimbursements should be shown in the remarks section of Form WC-4.

When salary is paid in lieu of income benefits, the period for which payments should have been made and the amount of income benefits that would have been paid must be shown in Section 2(a) and Section 4(1).

Subrogation reimbursement must be included in the amounts reported on Form WC-4, Section 2 (a) through (e) and Section 4 (1) through (11). The recovery of the insurer/self-insurer should be shown in the remarks section of the Form WC-4.

3. Enter the first disability date which is the first day on which the employee originally lost time from work due to the injury or occupational disease. This date should be the same on subsequent reports (Form WC-4) filed.

4. Section 4, Subsections 1 through 11 must show all payments as of the date the WC-4 is filed, less reimbursements made by the Subsequent Injury Trust Fund.

a. Section 4(1), Total Weekly Benefits. The amount shown must be the total of all payments shown in Subsections (a) through (e), Section 2, less reimbursements made by the Subsequent Injury Trust Fund.

b. Section 4(2), Physician. Show all payments made directly to a physician or medical group, not a hospital or hospital clinic.

c. Section 4(3), Hospital. Show all payments made to hospitals. Include emergency room, outpatient care, inpatient care, and other services provided by hospitals.

d. Section 4(4), Pharmacy. Show all payments to pharmacies, including reimbursement for drugs.

e. Section 4(5), Physical Therapy. Show all payments for physical therapy, including education, (not hospital or hospital clinic.)

f. Section 4(6), Chiropractic. Show all payments to a doctor of chiropractic medicine or chiropractic clinic.

The cost of medical care does not include any payments made for utilization or bill review.

g. Section 4(7), Other (Specify). Show other related expenses which do not belong in another category. These include travel expenses (meals, lodging, mileage, etc.,) home health care, nursing home care, home modifications, and automobile or van modifications.

h. Section 4(8), Rehabilitation. Show services of rehabilitation suppliers and training expenses (supplier fees, tuition, fees, books, supplies, mileage for rehabilitation suppliers, etc.)

i. Section 4(9), Late payment Penalties. Show payment of all 15% and 20% late payment penalties provided for in O.C.G.A. §34-9-221(e) and (f).

j. Section 4(10), Assessed Attorney's Fees. Show attorney's fees assessed as a penalty pursuant to O.C.G.A. §34-9-108(b). Do not show normal payment of attorney fees which are part of the employee's benefit or part of a settlement. These must be shown in Section 2 and Section 4(1). Do not show payments to the attorney for the employer/insurer.

k. Section 4(11), Burial. Show burial expenses when paid. Maximum is $7,500.

Section 5 must be completed when the employee returns to work.

Sections 6 through 11 should be completed if applicable at time of filing.

The amount of subrogation recovery or Subsequent Injury Trust Fund reimbursements (Indemnity and Medical) should be shown in the remarks section of Form WC-4.

Provide name and address of the insurer/self-insurer. If the insurer is part of a group that is using preprinted forms for more than one company, the name of the company insuring the loss must be indicated. If the claim is handled by a third party administrator (TPA) provide the name of the insurer/self-insurer and name and address of the TPA.

Type or print the name of the insurer or self-insurer representative completing the form and place on top of any accompanying forms. Include the phone number of the person authorized to discuss any questions regarding the information contained in Form WC-4.

FORM WC-6 WAGE STATEMENT

WHAT: Use Form WC-6 to compute the average weekly earnings of the injured worker or a similar employee.

WHO TO WHOM: The employer completes wage information and sends to the insurer claims office. Insurer/self-insurer submits to the State Board of Workers' Compensation when the weekly benefit is less than the maximum.

WHEN: Upon knowledge of a disabling work related injury or occupational disease (use back of Form WC-1.) Also used to established wage loss for temporary partial disability when the employee returns to work at reduced earnings.

COMPLETING THE FORM:

Complete identifying information. Enter employee name and address, the name and address of the employer, employee's social security number, the date of injury and the county where the injury occurred.

- Write the name of the similar employee in Section B if the injured employee has not worked substantially the whole of 13 weeks.

- Enter the number of hours the employee worked per day or week.

- Enter the number of days the employee worked per week.

- Enter the employee's wage at date of injury.

- Enter any wage rate changes.

- Complete the schedule showing gross weekly earnings for the 13 weeks immediately preceding the accident.

- Include wages earned at any similar concurrent employment during the 13-week period.

- Type or print the name of the person completing the form, sign the form, list the date the form was completed and the phone number of the representative completing the form.

FORM WC-26 CONSOLIDATED YEARLY REPORT OF MEDICAL ONLY CASES

WHAT: **A MEDICAL ONLY CLAIM** is a claim which paid only medical expenses for a work injury that has seven or less days of lost time from work.

WHO TO WHOM: The insurer/self-insurer submits this form to the State Board of Workers' Compensation.

WHEN: Yearly, on or before the 31st day of January following the end of each calendar year.

COMPLETING THE FORM:

It is the responsibility of the insurer or self-insurer to consolidate all individual TPA and claims office reports into one report (Form WC-26) and submit yearly to the State Board. The total number of cases and total money reported is for a calendar year January 1st to December 31st. File annually even if no reportable injuries or payments occurred during the reporting year.

- Complete the large block with the name of the insurer, self-insurer or group self-insurer as certified by the State Board of Workers' Compensation. **THIS SHOULD NOT BE THE NAME OF A THIRD PARTY ADMINISTRATOR.**

- Report separately those medical only injuries and payments of employers utilizing a Certified Workers' Compensation Managed Care Organization (WC/MCO).

- Enter the total number of non-WC/MCO medical only injuries reported during the calendar year. If no new injuries were reported, enter "0".

- Enter the total amount paid for non-WC/MCO medical only claims during the calendar year. If no medical only payments were made, enter "0".

- Enter the total number of WC/MCO medical only injuries reported during the calendar year. If no new injuries were reported, enter "0".

- Enter the total amount paid for WC/MCO medical only claims during the calendar year. If no medical only payments were made, enter "0".

- Type or print the name of the insurer/self-insurer representative completing the form, the telephone number, date the report was completed and the reporting year.

- Enter the address of the office submitting the form.

NOTE: DO NOT REPORT ANY MEDICAL ONLY EXPENSES ON FORM WC-4.